MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

DC 17685

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton | LENGTH OF STAY (In this place) 4 mos. 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore -17-
STREET ADDRESS (If rural, give location) 1124 N. Stockton Street

3. NAME OF DECEASED (Type or Print): (First) DELORES (Middle) S. (Last) ADAMS

4. DATE OF DEATH: (Month) August (Day) 6, (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 5-16-28

9. AGE last birthday: 21 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Adams

14. MOTHER'S MAIDEN NAME: Elizabeth Arthur

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: ?

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	December
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	1948
	(c)	

002
131

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 19 49, to Aug. 6, 19 49, that I last saw the deceased alive on Aug. 6, 19 49, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M. D. | ADDRESS: Henryton, Maryland | DATE SIGNED: 8-6-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Aug 9 1949 | NAME OF CEMETERY OR CREMATORY: Mt. Calvary | LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG. 8-6-49 | REGISTRAR'S SIGNATURE: Albert R. Somerkamp Deputy Local | 24. FUNERAL DIRECTOR: Geo. B. Nelson | ADDRESS: 1303 Pennsylvania Ave.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
AUG 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07686

Reg. Dist. No. 82

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Airy
LENGTH OF STAY (In this place) 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Mt. Airy
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Anne (Last) Allen

4. DATE OF DEATH: (Month) Aug. (Day) 1, (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9-5-1873

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Brown

14. MOTHER'S MAIDEN NAME: Maria Hartaubarr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Ralph E. Wallace

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Conjestive Heart Failure	2 da
Antecedent cause(s)		
422.1 / 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Cardio-Vascular Desease	3 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis Deformans — 23 yrs

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 6, 1949, to August 1, 1949, that I last saw the deceased alive on July 31, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J Stanley Grabill M.D. Mt. Airy, Md. 8/1/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
Removal | 8-2-1949 | | Winnebago. Minn.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS
Aug 2/49 | Thos O Snyder | C. M. Waltz | Winfield Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

Evidence of change of age is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07687

FILM No. G 121 AUG -9 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington DC
STREET ADDRESS (If rural, give location) 603 Eleventh St. N.E.

3. NAME OF DECEASED (Type or Print): (First) Martha (Middle) Agnes (Last) Anderson

4. DATE OF DEATH: (Month) Aug (Day) 3 (Year) 1949

5. SEX: F. — 6. COLOR OR RACE: W. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single — 8. DATE OF BIRTH: 8-4-87 — 9. AGE last birthday: 61 yrs. — If under 1 year: Months 11, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Virginia — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Andrew Anderson — 14. MOTHER'S MAIDEN NAME: Martha Turney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mrs David Fletcher

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	1 da
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Gen Arterio Sclerosis	8 yrs
	(c) Hypertension	"

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 22, 1944, to Aug 3, 1949, that I last saw the deceased alive on Aug 3, 1949, and that death occurred at 3-05 P m., from the causes and on the date stated above.

SIGNATURE W. Martin M.D. (Degree or title) — ADDRESS Sykesville Md — DATE SIGNED Aug 3-49

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: Aug 3, 1949 — NAME OF CEMETERY OR CREMATORY: Washington D.C. — LOCATION (City, town, or county) (State): Washington D.C.

DATE REC'D BY LOCAL REG.: Aug 3, 1949 — REGISTRAR'S SIGNATURE: Harry Keen

24. FUNERAL DIRECTOR — ADDRESS: The S. H. Hines Company. 2401-14th St. N.W. Washington, D.C.

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 07688

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): since 12/22/39	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS: --- (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	William	-	BAIN		August	22	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	Dec. 12, 1886	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknown	unknown	unknown	unknown

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
unknown	---	unknown	Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma of the stomach	more than 1½ months
151 Antecedent cause(s)		
468 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Liver cirrhosis and Korsakoff's psychosis	10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
---	---	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
---	---	---		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
--- m.		---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Aug. 22, 1949, that I last saw the deceased alive on August 22, 1949, and that death occurred at 3:45 P.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) — ADDRESS: Sykesville, Maryland — DATE SIGNED: 8/22/49

Martin Gross, M. D.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-24-49	Springfield Hosp.	Sykesville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
8-24-49	C. Harry Weer	C. H. Weer - Sykesville, Md.

RECEIVED
AUG 26 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07689

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll County

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred: Pleasant Valley Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pleasant Valley Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William E. Ball

3.(b) Social Security Number: 213 05 9006

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Widow

6.(b) Name of husband or wife: late Carrie E. (nee Schaeffer)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 23, 1884

8. AGE: Years: 65 Months: Days: 2 If less than one day ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Baltimore Transit Co.

FATHER
12. Name: Ball
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary----
15. Birthplace: Md.

16. Informant: John E. Ball (Son)
Address: Westminster, R. D. # 2.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 27 /49 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Woodlawn, Md.

18. Funeral director: Harry H. Witzke
Address: 4101 Edmondson Ave.

19. Aug 27th 1949 (Date rec'd by registrar) R.W. A.W. Heduck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25/49 19..... at 1:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1949, to August 25 1949 and that I last saw him alive on August 25, 1949

Immediate cause of death: Chronic myocarditis & Valvular Insufficiency Prostatic Hypertrophy — DURATION

Due to: Arteriosclerosis General — 10 yrs

Due to:

Other conditions: Cerebral Hemorrhage + Spastic paralysis — 1947
(Include pregnancy within 3 months of death)

Major findings of operations: 422.1 82 Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Md. Date signed: 8/25/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07690

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield St. Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 28
STREET ADDRESS (If rural, give location) 6224 Frederick Road

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Margaret (Last) Becker
4. DATE OF DEATH: (Month) Aug. (Day) 12 (Year) 1949

5. SEX: fem.
6. COLOR OR RACE: wh.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 8.27.81
9. AGE last birthday: 67 yrs. | If under 1 year: Months. 11 Days 25 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Maisel
14. MOTHER'S MAIDEN NAME: Elenora Dill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)
16. SOCIAL SECURITY No. ?
17. INFORMANT: husband Mr. William F. Becker.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bilateral Bronchopneumonia	48 h.
450.0 Antecedent cause(s)		
107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis	11 years
	(c) Psychosis with cerebral arteriosclerosis	8 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ✓
19b. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ✓
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ✓ (CITY OR TOWN): ✓ (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ✓
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from October, 1948, to Aug. 11, 1949, that I last saw the deceased alive on Aug. 11, 1949, and that death occurred at 1:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Elizabeth A. Winiarz | Springfield S.H. Sykesville Md | Aug. 12, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 8/15/49 | NAME OF CEMETERY OR CREMATORY: Salem Lutheran Cem. | LOCATION (City, town, or county): Catonsville (State): Md.
DATE REC'D BY LOCAL REG.: Aug. 12, 1949 | REGISTRAR'S SIGNATURE: C. Harry Weer
24. FUNERAL DIRECTOR: Easton Sons | ADDRESS: Ellicott City, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07624

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton; LENGTH OF STAY (in this place) 3 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Sana.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-17; STREET ADDRESS (If rural, give location) 1403 McCulloh Street

3. NAME OF DECEASED (Type or Print): (First) John; (Middle) Woodland; (Last) Blake Jr.

4. DATE OF DEATH: (Month) August; (Day) 27; (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: June 10, 1925

9. AGE last birthday: 24 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John W. Blake

14. MOTHER'S MAIDEN NAME: Catherine Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): II

16. SOCIAL SECURITY NO.

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002 Immediate cause (a) Pulmonary Tuberculosis — Interval Between Onset and Death: April, 1949

Antecedent cause(s)

131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 27, 1949, to Aug. 27, 1949, that I last saw the deceased alive on Aug. 27, 1949, and that death occurred at 1:20 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Reuben Hoffman, M.D. ADDRESS Henryton, Md. DATE SIGNED 8-27-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE 8/30/49 — NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem — LOCATION (City, town, or county) (State): Baltimore Co.

DATE REC'D BY LOCAL REG. 8-27-49 — REGISTRAR'S SIGNATURE Deputy Local

24. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home — 1631 Druid Hill Ave.

VS. A15

RECEIVED
AUG 30 1949
BUREAU V. S.

Evidence for addition of 18a shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07692

CERTIFICATE OF DEATH

FILM No. G 122 SEP 23 1949

Reg. Dist. No. 81

1. PLACE OF DEATH COUNTY: Carroll MARYLAND: Md	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural RFD.1 LENGTH OF STAY (in this place): 24 yr	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Union Bridge Md	STREET ADDRESS (If rural, give location): RFD.1 Union Bridge Md

3. NAME OF DECEASED (Type or Print)	(First) Gertrude	(Middle) Flora	(Last) Bowman	4. DATE OF DEATH	(Month) 8 (Day) 28 (Year) 1949
5. SEX: F	6. COLOR OR RACE: W	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH: 7-22-1899	9. AGE last birthday: 50 yrs.	If under 1 year: Months 1, Days 5; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Franklin County Va	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Benjaman Flora	14. MOTHER'S MAIDEN NAME: Elizabeth Flora				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Berkley O. Bowman			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Brain Tumor, malignant, primary (9/23/49 akc)	More than 1 yr
193 Antecedent cause(s)		
54 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1948	19b. MAJOR FINDINGS OF OPERATION: Tumor of Brain	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/6, 1948, to 8/28, 1949, that I last saw the deceased alive on 8-27, 1949 and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James F. Moore	M.D.	Westminster Md	8/29/49

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~	DATE: 8-30-49	NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery	LOCATION (City, town, or county): Near Uniontown (State) Md
DATE REC'D BY LOCAL REG.: Aug 29 1949	REGISTRAR'S SIGNATURE: Leslie L. Repp	24. FUNERAL DIRECTOR: Raymond K. Wright	ADDRESS: Md Union Bridge

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 31 1949
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc

07693

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place): 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 502 East 42 St

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Anna Virginia Cole
4. DATE OF DEATH (Month) (Day) (Year): Aug 9th 1949
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Jan 21-1879
9. AGE last birthday: 70 yrs. — If under 1 year: Months 6 Days 3 — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housing
10b. KIND OF BUSINESS OR INDUSTRY: Housing
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Wilcox
14. MOTHER'S MAIDEN NAME: Matilda Cochran
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT: William Cole

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 3 da

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Genl. Arterio Sclerosis — 10 yrs

331 83a (c) Hypertension — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 7th, 1944, to Aug 9, 1949, that I last saw the deceased alive on Aug 9th, 1949, and that death occurred at 5-14 P m., from the causes and on the date stated above.

SIGNATURE: W H Mastin (Degree or title) M.D. — ADDRESS: Sykesville Md — DATE SIGNED: Aug 9th 49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 8/12/49 — NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem. — LOCATION (City, town, or county) (State): Pikesville, Md.
DATE REC'D BY LOCAL REG.: 8/10/49 — REGISTRAR'S SIGNATURE: A. W. Heaney
24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07694

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 199 Penna. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; STREET ADDRESS (If rural give location) 199 Penna. Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Caroline	Belle Virginia	Dodrer	Aug.	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W	widow	July 19-1867	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Abraham Nusbaum

14. MOTHER'S MAIDEN NAME: Ellen Grount Fetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs John Lemmon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	7 days
422.1 Antecedent cause(s)	(b) Arteriosclerotic Cardio Vasc. Disease	30 yrs.
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Congestive heart failure	36 hrs.

19a. DATE OF OPERATION: no

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12, 1949, to 8/19, 1949 that I last saw the deceased alive on 8/19, 1949, and that death occurred at 8:55 P. p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) David Auld, MD. ADDRESS 102 E. Main St DATE SIGNED 8/20/49

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-22-1949	Bdgat Cemetery	Westminster R.D. 7. Md.

DATE REC'D BY LOCAL REG. 8/22/49

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS: H Bankard Son. Westminster, Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 07695

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (In this place): 27 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS: unknown (If rural give location) ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Henrietta		Doering	August,	21	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	widowed	4-29-1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	none	Germany	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Wedjen	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic myocarditis and myocardial degeneration	6 weeks
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (422.1 / 93d)	(b) Generalized arteriosclerosis	about 10 years
	(c)	
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Schizophrenia, paranoid type	about 50 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-2- 42, to 8-21 49, that I last saw the deceased alive on 8-21 49, and that death occurred at 3.20 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Irene L. Hohman, M.D.		Springfield State Hospital	8-21-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8/24/49	LOUDON PARK	BALTIMORE	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/24/49	A. W. Hedrich	J. STANSBURY	2700 EDMONDSON AVE
		LITTLES FUNERAL HOME	

VS-A15

Evidence for change in #4 & 22 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07696

CERTIFICATE OF DEATH

Reg. Dist. No. 74

File No. C-121 SEP -9 1949

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville; LENGTH OF STAY (in this place) 7 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	CRASS	ELLIOT	8	23 28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. / Days	If under 24 hrs.: Hours / Min.
Male	W	Single	11/6/92	56 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, eveo if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clothes presser		Carroll County, Maryland	USA

13. FATHER'S NAME: Charles H. Elliot

14. MOTHER'S MAIDEN NAME: Mary C. Crass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
yes	unknown		Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemmorrhage from varicosities of esophagus and edema of brain.	1 day
581.1 Antecedent cause(s)		
124a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cirrhosis of the liver due to chronic alcoholism.	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the deatb but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/16, 1949, to 8/22, 1949, that I last saw the deceased alive on 8/22 ~3, 1949, and that death occurred at 4:30 A DST m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gertrude M. Foos,	M.D	Sykesville, Maryland	8/22/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-25-49	St Josephs	Taneytown,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 23, 1949	C. Harry Weaver	C. O. Fuss & Son	Taneytown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

07697

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (In this place): 37 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ?
STREET ADDRESS (If rural, give location): ?

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) G. (Last) Ely

4. DATE OF DEATH: (Month) August (Day) 21 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 1884

9. AGE last birthday: 65 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles W. Ely

14. MOTHER'S MAIDEN NAME: Mary Darling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service): --

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	8 days
410 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 92b	(b) Mitral stenosis and insuff.	20 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. schizophrenia, hebephrenic type more than 37 yrs

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): ---

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---
(CITY OR TOWN): ---
(COUNTY):
(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): ---
m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?: ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Aug. 21, 1949, that I last saw the deceased alive on Aug. 20, 1949, and that death occurred at 9.14 a.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title)
Martin Gross, M.D.
ADDRESS: Sykesville, Md.
DATE SIGNED: 8-21-49

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE: 8-22-49
NAME OF CEMETERY OR CREMATORY:
LOCATION (City, town, or county) (State): Frederick, Md.

DATE REC'D BY LOCAL REG.: 8-22-49
REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR: M. R. Etchison & Son
ADDRESS: Frederick, Md.

RECEIVED
AUG 24 1949
BUREAU V. S.

07698

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge — LENGTH OF STAY (in this place): Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Linwood
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rural	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) SEWARD (Middle) S. (Last) ENGLAR

4. DATE OF DEATH: (Month) Aug (Day) 17 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4/16/1891

9. AGE last birthday: 58 yrs. — If under 1 year: Months 58 Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter - paper hanger

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? A. S.

13. FATHER'S NAME: Frank J. Englar

14. MOTHER'S MAIDEN NAME: Minnie A. Devilbiss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Adalarde A. Englar

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Disease of Coronary Arteries

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) none (Had an acute attack while

(c) — riding a mowing machine

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none. on fell off by lane).

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) Westminster (COUNTY) Carroll (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐ —

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased ~~from~~ on 8-17, 1949, to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE: C. L. Billingsley, M.D. (Degree or title) ADDRESS: Westminster, Md. DATE SIGNED: 8-19-49

acting Deputy Medical Examiner for Carroll County

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 8/21/49 — NAME OF CEMETERY OR CREMATORY: Pipe Creek Cem. — LOCATION (City, town, or county): Uniontown Road (State)

DATE REC'D BY LOCAL REG.: Aug 19, 1949 — REGISTRAR'S SIGNATURE: Leslie G. Kepp

24. FUNERAL DIRECTOR: W. D. Hartzler & Sons — ADDRESS: Union Bridge & New Windsor, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 07699

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton | LENGTH OF STAY (in this place): 1 mos., 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore- 1 -
STREET ADDRESS (If rural, give location): 836 W. Fayette Street ✓

3. NAME OF DECEASED (Type or Print): (First) NATHANIEL (Middle) (Last) ERVIN

4. DATE OF DEATH: (Month) August (Day) 22, (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 9-21-14

9. AGE last birthday: 34 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Darlington, South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nathaniel Ervin

14. MOTHER'S MAIDEN NAME: Essie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Frances Ervin-Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — June

002 Antecedent cause(s) — 1948

138 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 19 49, to Aug. 22, 19 49, that I last saw the deceased alive on Aug. 22, 19 49, and that death occurred at 10:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. — ADDRESS: Henryton, Maryland — DATE SIGNED: 8-22-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 8-25-49 | NAME OF CEMETERY OR CREMATORY: Mt. Albion Cemetery | LOCATION (City, town, or county) (State): Maryland

DATE REC'D BY LOCAL REG. 8-22-49 | REGISTRAR'S SIGNATURE: Albert B. Counselman, Deputy Local | 24. FUNERAL DIRECTOR: William A. Jackson | ADDRESS: 916 Penna Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 24 1949
BUREAU T. S.

07700

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Valentine (Last) Fredrick
4. DATE OF DEATH (Month) August (Day) 16 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Dec 3, 1878
9. AGE last birthday 70 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob A. Fredrick
14. MOTHER'S MAIDEN NAME Elizabeth G. Stine
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 217-28-5537
17. INFORMANT Jacob A Fredrick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 6 days

420.1 Antecedent cause(s) (b) Arterio-Sclerotic Cardio-Vascular Disease — ?

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Chronic Myocarditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Oct 2, 1946, to Aug 16, 1949, that I last saw the deceased alive on Aug 16, 1949, and that death occurred at 10:40 P.m., from the causes and on the date stated above.

SIGNATURE Joseph E. Bush (Degree or title) M.D. ADDRESS Hampstead Md DATE SIGNED Aug 16, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug 19/49
NAME OF CEMETERY OR CREMATORY Manchester
LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Aug 18/49
REGISTRAR'S SIGNATURE Mrs. W. R. S. Denner
24. FUNERAL DIRECTOR Edw C Tipton, ADDRESS Hampstead Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 30 1949
BUREAU V. S.

07701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge Rural — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Union Bridge Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) Effie	(Middle) M	(Last) Fuss	4. DATE OF DEATH	(Month) Aug	(Day) 7	(Year) 1949
5. SEX: Female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Aug 17-1864	9. AGE last birthday: 84 yrs.	If under 1 year: Months.	Days	If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: John Geiger	14. MOTHER'S MAIDEN NAME: Louisa Shriner						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Miss Pauline Fuss					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiac Failure	5 days
422.2 Antecedent cause(s)	(b) Chronic Myocarditis	?
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 30, 1949, to Aug 7, 1949, that I last saw the deceased alive on Aug 7, 1949, and that death occurred at 3 30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
	T. H. Legg M.D.	Union Bridge	8-7-49.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 10-1949	Winters Cemetery	Union Bridge-New Windsor Road Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 8, 1949	Leslie L. Repp	D. D. Hutzler & Sons	Union Bridge & New Windsor, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07702

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll County; MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md.
   LENGTH OF STAY (In this place) 4 years
   HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shallmar
   STREET ADDRESS (If rural, give location) ---

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) W. (Last) Grimes

4. DATE OF DEATH: (Month) 8 (Day) 28 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): div.

8. DATE OF BIRTH: 8-7-1878

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Preston County, West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John E. Grimes

14. MOTHER'S MAIDEN NAME: Emma Mercer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) /
    (If year, give war or dates of service) /

16. SOCIAL SECURITY NO. /

17. INFORMANT: Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Broncho-pneumonia	2 days
491 Antecedent cause(s)		
107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Chronic alcoholism without psychosis	14 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION /

19b. MAJOR FINDINGS OF OPERATION /

20. AUTOPSY? Yes ☐ No ☐ /

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) /

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) / (CITY OR TOWN) / (COUNTY) / (STATE) /

TIME OF INJURY (Month) / (Day) / (Year) / (Hour) / m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? /

22. I hereby certify that I attended the deceased from February 19 46, to 8-28, 19 49, that I last saw the deceased alive on 8-28-49, and that death occurred at 8:46 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph H. Marshall, M.D. Springfield State Hospital 8-28-1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Sept. 1, 1949 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | LOCATION (City, town, or county) Thomas (State) W. Va.

DATE REC'D BY LOCAL REG. Aug. 29, 1949 | REGISTRAR'S SIGNATURE Nancy Keer | 24. FUNERAL DIRECTOR Dale Duncan ADDRESS Thomas, W. Va.

RECEIVED
SEP 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 07703

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 71

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton; LENGTH OF STAY (In this place) 10 mos.,8 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-26-; STREET ADDRESS (If rural, give location) 1720 Locust Street

3. NAME OF DECEASED (Type or Print): (First) MABLE (Middle) (Last) HARRISON

4. DATE OF DEATH: (Month) August (Day) 23, (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 13, 1924

9. AGE last birthday: 25 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Tom's Creek, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Julius Hawkins

14. MOTHER'S MAIDEN NAME: Hettie Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval between onset and death: July, 1948

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 15, 48, to Aug. 23 49, that I last saw the deceased alive on Aug. 23, 1949, and that death occurred at 9:25 a.m., from the causes and on the date stated above.

SIGNATURE Herbert W Hoffman, M.D. (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 8-23-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Aug 25th/49 NAME OF CEMETERY OR CREMATORY Mt Calvary LOCATION (City, town, or county) Brookland Md (State)

DATE REC'D BY LOCAL REG. 8-23-49 REGISTRAR'S SIGNATURE Albert R Swankhaus Deputy Local

24. FUNERAL DIRECTOR Elroy O Wilson ADDRESS 1600 Brantley Av

RECEIVED
AUG 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

07704

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 2 mos. 18 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-30
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Sana.	STREET ADDRESS (If rural, give location) 528 W. Conway Street

3. NAME OF DECEASED (Type or Print)	(First) Eva	(Middle) Mae	(Last) Henry	4. DATE OF DEATH (Month) August	(Day) 27 (Year) 1949
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH February 1, 1929	9. AGE last birthday 20 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Work	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lamar, S. Caroline	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Frank Henry	14. MOTHER'S MAIDEN NAME Frances Williams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Jan. 1, 1949

002 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

13b (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 9, 1949, to Aug. 27, 1949, that I last saw the deceased alive on Aug. 27, 1949, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Md.	8-27-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 8-30-49	NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	LOCATION (City, town, or county) (State) Baltimore, Md.
DATE REC'D BY LOCAL REG. 8-27-49	REGISTRAR'S SIGNATURE Albert R. Swanthaus	24. FUNERAL DIRECTOR Walter B Spigg C	ADDRESS 139 W. Hamburg 8

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 30 1949
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07705

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural near Westminster; HOSPITAL OR INSTITUTION OR STREET ADDRESS; MARYLAND; LENGTH OF STAY (in this place) 39 years

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, near Westminster; STREET ADDRESS (If rural give location) Rt. Cranberry station

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
AMANDA	FLORENCE	HULL	Aug.	4	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
F.	W.	Widowed	May 24 1887	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House-wife		Carroll Co. Md.	U. S. A.

13. FATHER'S NAME Dallas Albaugh

14. MOTHER'S MAIDEN NAME Lydia Lipster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
			Herbert A. Hull

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Arteriosclerosis	years.
331 / 82a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ..., 1945, to Aug 4, 1949, that I last saw the deceased alive on Aug 3, 1949, and that death occurred at 11:10 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James F. Marker	M.D	Westminster Md	8/5/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 8/49	Reading Cemetery	Westminster Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/6/49	[illegible]	J. S. Myers Jr.	Westminster Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 8 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 07706

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (in this place) 7 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore

STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) Jessup (Last)

4. DATE OF DEATH (Month) Aug (Day) 7th (Year) 1949

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single | 8. DATE OF BIRTH 1881 | 9. AGE last birthday 68 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY Dependent | 11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leonard Jessup | 14. MOTHER'S MAIDEN NAME Rebeccat unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs William Ryan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	6 hrs
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis	10 yrs
94a	(c) Epilepsy	17 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 24, 1942, to Aug 9, 1949, that I last saw the deceased alive on Aug 9, 1949, and that death occurred at 12-25 p m., from the causes and on the date stated above.

SIGNATURE M J Martin MD (Degree or title) ADDRESS Sykesville Md DATE SIGNED Aug 9th 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 8-12-49 | NAME OF CEMETERY OR CREMATORY London Park | LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REG. Aug. 11, 1949 | REGISTRAR'S SIGNATURE C Harry Weer | 24. FUNERAL DIRECTOR George A Farley - Frederick & Shady Nook Ave Catonsville ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 13 1949.
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

BC 07707

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (In this place) since 6/22/18
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS --- (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) - (Last) JOFFE
4. DATE OF DEATH: (Month) August (Day) 16 (Year) 1949
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: 7/10/1896
9. AGE last birthday: 53 yrs. If under 1 year: Months - Days - If under 24 hrs.: Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd jobs
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Philadelphia, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Samuel Joffe
14. MOTHER'S MAIDEN NAME: Cecilia Hessalber
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unkn. (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic endocarditis with mitral stenosis and insufficiency. — more than 16 yrs.

410

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

926

(b) ---

(c) ---

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, hebephrenic type — more than 30 yrs.

19a. DATE OF OPERATION: ---
19b. MAJOR FINDINGS OF OPERATION: ---
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): --- PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --- (CITY OR TOWN) --- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: --- INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to August 16 1949, that I last saw the deceased alive on Aug. 16, 1949, and that death occurred at 12 noon M., from the causes and on the date stated above.

SIGNATURE Martin Gross M.D. (Degree or title) — ADDRESS Martin Gross, M.D. Sykesville, Maryland — DATE SIGNED 8/16/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 8-18-49 — NAME OF CEMETERY OR CREMATORY Hebrew Herring Rest — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. Aug. 16, 1949 — REGISTRAR'S SIGNATURE C. Harry Lewis — 24. FUNERAL DIRECTOR Jack Lewis Inc. — ADDRESS 2100 Eutaw Place Balto. Md.

RECEIVED
AUG 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Be 07708

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton; LENGTH OF STAY (In this place): 4yrs. 5mos. 3days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Baltimore 30; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ; STREET ADDRESS (If rural, give location): 1108 Leadenhall St., ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DOROTHY	ELSIE	JONES	Aug.,	2	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Sep	Feb., 3, 1921	28 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Defense Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ISAAC MINOR

14. MOTHER'S MAIDEN NAME: HARRIET HOLLOWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-16-8939

17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	July, 1944
Antecedent cause(s) 002		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 138	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb., 9, 19 45, to Aug., 2, 19 49, that I last saw the deceased alive on Aug., 2, 19 49, and that death occurred at 2:35 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Md.	8/2/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug 6 49	Mt Calvary Cmt	B.A.Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/2/49	Albert R. Lenhardt Deputy Local	LAIDLAW BROWNSON	10 Montgomery St

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 6mos. 21 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 2 College Creek Terrace

3. NAME OF DECEASED (Type or Print): (First) EVELYN (Middle) (Last) JONES

4. DATE OF DEATH: (Month) August (Day) 8 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 9, 1925

9. AGE last birthday: 24 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Noble Watkins

14. MOTHER'S MAIDEN NAME: Lillian Lomac

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: ?

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) -- Pulmonary Tuberculosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

002

138

INTERVAL BETWEEN ONSET AND DEATH: March, 1948

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 17, 1949, to Aug. 8, 1949, that I last saw the deceased alive on Aug. 8, 1949, and that death occurred at 9:45 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. — ADDRESS: Henryton, Maryland — DATE SIGNED: 8-8-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Aug. 10, 1949 — NAME OF CEMETERY OR CREMATORY: Fowlers Chapel Cemetery — LOCATION (City, town, or county) (State): Best Gate, Maryland

DATE REC'D BY LOCAL REG.: 8-8-49 — REGISTRAR'S SIGNATURE: Albert [illegible] Deputy Local

24. FUNERAL DIRECTOR — ADDRESS: Mrs Charles E. Hicks & Son, 45 northwest st annapolis Md.

RECEIVED
AUG 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7J

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; LENGTH OF STAY (in this place) 79 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) J. (Last) LaMatte

4. DATE OF DEATH: (Month) 8 (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 7-19-1870

9. AGE last birthday: 79 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Manchester Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John H. LaMatte

14. MOTHER'S MAIDEN NAME: Mary B. Streveig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss. Fedna LaMatte

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Heart Block — Interval Between Onset and Death: 2 days

Antecedent cause(s) 420.1 82 — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carmary Arterio-sclerosis — 20 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. Bubar Palsy

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-7, 1949, to 8-9, 1949, that I last saw the deceased alive on 8-8, 1949 and that death occurred at 8:30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Maurice C. Parkinson M.D. ADDRESS: Hospital, Md. DATE SIGNED: 8/10/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 8-11-49 — NAME OF CEMETERY OR CREMATORY: Manchester Cemetery — LOCATION (City, town, or county): Manchester (State): Md.

DATE REC'D BY LOCAL REG.: Aug 10/49 — REGISTRAR'S SIGNATURE: Mrs. H. G. L. Denner

24. FUNERAL DIRECTOR: Jacob Winter's Sons — ADDRESS: Manchester, Md.

RECEIVED
AUG 17 1949
BUREAU Y. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07711

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (in this place) 6 Wks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster	STREET ADDRESS (If rural, give location) Westminster

3. NAME OF DECEASED (Type or Print)	(First) Margaret	(Middle) Annie	(Last) McComas	4. DATE OF DEATH	(Month) August (Day) 12 (Year) 1949
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH Apr 26 1859	9. AGE last birthday 90 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Joshua Silas Shipley	14. MOTHER'S MAIDEN NAME Susan Zile				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Aquilla McComas			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis + chronic decompensating — 3 yrs

Antecedent cause(s) (b) Uremic coma — 1 week

442 131a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerotic cardio-vascular - renal disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-, 1939, to 8-12-, 1949, that I last saw the deceased alive on 8/11, 1949, and that death occurred at 3:30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] M. D. Reisterstown Md 8/13/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Aug 15 1949	NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	LOCATION (City, town, or county) Reisterstown (State) Md
DATE REC'D BY LOCAL REG. 8/16	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Wm Berryman & Sons	ADDRESS Reisterstown Md

RECEIVED
AUG 17 1949
BUREAU V. S.

(2) 71712

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

not BC

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Carroll

City or town: Reese, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 841 Brinkwood Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Louise Mohr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: late John Charles Mohr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2, 1873

8. AGE: Years	Months	Days	If less than one day
76	5	8	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: H.W.

11. Industry or business

FATHER
12. Name: Melchior Jordan
13. Birthplace: Germany

MOTHER
14. Maiden name: Gertrude------
15. Birthplace: Germany

16. Informant: J. W. Mohr, (Son)

Address: 841 Brinkwood Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 13/49 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: 3801 Frederick Rd. Baltimore, Md.

18. Funeral director: Harry H. Witzke

Address: 4101 Edmondson Ave.

19. 8-12 1949 (Date rec'd by registrar) R. H. Hedrick M.R.G. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10/49 1949 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1949 to Aug 10 1949 and that I last saw her alive on Aug 6, 1949

Immediate cause of death: Cerebral softening

DURATION: 3 yrs

Due to

Due to

Other conditions: 332 83c
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: E. Reese Wilkens M. D. or other

Address: 78 W. Main Westminster Date signed: 8/11/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 07713

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville; LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural give location): 3602 Glengyle Ave
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Sydney Newton	4. DATE OF DEATH (Month) (Day) (Year): Aug 9th 1949
5. SEX: T; 6. COLOR OR RACE: W; 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single; 8. DATE OF BIRTH: Sept 17-1867	9. AGE last birthday: 81 yrs. If under 1 year: Months 10, Days 28; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY: Housework; 11. BIRTHPLACE (State or foreign country): Wales; 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas G Newton	14. MOTHER'S MAIDEN NAME: Frances Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):	16. SOCIAL SECURITY NO.: ; 17. INFORMANT: Mrs John E Henderson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	3 yrs
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Genl Arterio Sclerosis	7 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 10, 1945, to Aug 9, 1949, that I last saw the deceased alive on Aug 9, 1949, and that death occurred at 3 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M. H. Martin	M.D.	Sykesville Md	Aug 9-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-11/49	London Park	Baltimore City

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/10/49	A. W. Hedrick	Loring Byers	5005 Ph Hgts Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07714

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Owen (Middle) Henry (Last) Norris

4. DATE OF DEATH (Month) August (Day) 4 (Year) 1949

5. SEX M

6. COLOR OR RACE Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Aug. 21, 1897

9. AGE last birthday 51 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Norris

14. MOTHER'S MAIDEN NAME Laura Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY No. 212-16-2952

17. INFORMANT James Norris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrage — INTERVAL BETWEEN ONSET AND DEATH: Short

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hardis Vascular disease — time

93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Sykesville (COUNTY) Carroll (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Aug 3 1949, that I last saw the deceased alive on Aug 7, 1949, and that death occurred at 3 A.M. m., from the causes and on the date stated above.

SIGNATURE N. H. Barnes (Degree or title) MD ADDRESS Sykesville Md DATE SIGNED 8/4/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 8-6-49

NAME OF CEMETERY OR CREMATORY St Luke's

LOCATION (City, town, or county) Sykesville, Md. (State)

DATE REC'D BY LOCAL REG. Aug. 5, 1949

REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR C. H. Weer ADDRESS Sykesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 8 1949
BUREAU V. S.

Evidence for change of birth date & age is on FILM No. G 121 SEP -9 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07715

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 5-8-5
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Mont
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 4910 St Elmo Ave

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Elizabeth (Last) Parker

4. DATE OF DEATH: (Month) 8 (Day) 5 (Year) 1949

5. SEX F — 6. COLOR OR RACE W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed — 8. DATE OF BIRTH Aug 11 1867 — 9. AGE last birthday 81 yrs. — If under 1 year: Months, Days, Hours, Min. 1 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Prince Georges Co Md — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Augustus Royce — 14. MOTHER'S MAIDEN NAME Harriett Hazly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY No. — 17. INFORMANT Mrs Hilda Pugh

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypostatic Pneumonia — 1 da

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gen Arterio Sclerosis — 5 yrs

447 97

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 2, 1947, to Aug 5, 1949, that I last saw the deceased alive on Aug 5, 1949, and that death occurred at 2:55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W H Gaston MD — ADDRESS Sykesville Md — DATE SIGNED Aug 5-49

23. BURIAL, CREMATION, REMOVAL (Specify) Removal — DATE THEREOF Aug 5, 1949 — NAME OF CEMETERY OR CREMATORY Washington D.C. — LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. Aug 5, 1949 — REGISTRAR'S SIGNATURE C Harry Weer

24. FUNERAL DIRECTOR — ADDRESS W. W. Chambers Co., Washington, D.C.

VS. A15

RECEIVED
AUG 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07716

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State San.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore-22
STREET ADDRESS (If rural, give location): 11 Norris Lane

3. NAME OF DECEASED (Type or Print): (First) Anthony (Middle) Robert (Last) Perrin

4. DATE OF DEATH: (Month) August (Day) 13 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 9, 1948

9. AGE last birthday: 10 mos. yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Perrin

14. MOTHER'S MAIDEN NAME: Luvina Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Luvina Perrin (Mother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Tuberculous Meningites	8-6-49
002 Antecedent cause(s) 131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary Tuberculosis	7-1-49
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 3, 1949, to Aug. 13, 1949, that I last saw the deceased alive on Aug. 13, 1949, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. — ADDRESS: Henryton, Md. — DATE SIGNED: 8-13-49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial — DATE: Aug 16th 49 — NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetary — LOCATION (City, town, or county) (State): Brookland Md.

DATE REC'D BY LOCAL REG. 8-13-49

REGISTRAR'S SIGNATURE: Albert R. Turnbaugh

Deputy. Local

24. FUNERAL DIRECTOR: Elroy O Wilson — ADDRESS: 1005 Brantley Av

VS. A15

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AUG 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07717

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Winfield
LENGTH OF STAY (in this place): 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Winfield
STREET ADDRESS (If rural, give location): RURAL-- Sykesville

3. NAME OF DECEASED (Type or Print): (First) NICHOLAS (Middle) G. (Last) PICKETT

4. DATE OF DEATH: (Month) Aug (Day) 12 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 2-26-1868

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George H. Pickett

14. MOTHER'S MAIDEN NAME: Mary D. Grove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT: Mrs. John S. Barnes, Sykesville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Stomach with

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Metastasis -

151
468

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 9 1949

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-28-, 1949, to 8-11-, 1949, that I last saw the deceased alive on 8-10-, 1949, and that death occurred at 2 A. m., from the causes and on the date stated above.

SIGNATURE: C. M. Waltz (Degree or title) MD ADDRESS Mt Airy Md DATE SIGNED 8-13-49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL
DATE THEREOF: 8-14-1949
NAME OF CEMETERY OR CREMATORY: Morgan Chapel
LOCATION (City, town, or county) (State): Woodbine, Carroll Co. Md

DATE REC'D BY LOCAL REG. 8-13-49
REGISTRAR'S SIGNATURE: E. M. Farver

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, ADDRESS Md.

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AUG 17 1949
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 07718

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND; CITY OR TOWN: Henryton; LENGTH OF STAY (in this place): 1yr. 18 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State San.	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: ; CITY OR TOWN: Baltimore- 5; STREET ADDRESS (If rural, give location): 1629 McElderry Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Dorothy		Rich	August	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Sep.	June 6, 1922	27 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Operator		Baltimore, Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Whitlor	Rose Haymond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	219-16-9944	Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	June, 1948
Antecedent cause(s) 002		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 136	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from August 2, 1948, to August 20 1949, that I last saw the deceased alive on Aug. 20, 1949, and that death occurred at 6:30 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hyman, M.D.	Henryton, Md.	8-20-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8-24-49	MT. CALVARY	A.A. Co., MD.,

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-20-49	Albert A. Smithland Deputy Local	Wm. A. Jackson - 916 Penna. Ave.	Baltimore 1., MD.,

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AUG 23 1949
BUREAU V. S.

07719

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (Rural) | LENGTH OF STAY (In this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead - Rural
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) G (Last) RILL

4. DATE OF DEATH: (Month) aug (Day) 17 (Year) 1949

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M | 8. DATE OF BIRTH: apr 17 1896 | 9. AGE last birthday: 53 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer | 10b. KIND OF BUSINESS OR INDUSTRY: — | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel Rill | 14. MOTHER'S MAIDEN NAME: Mary E Zepp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No | 16. SOCIAL SECURITY NO.: — | 17. INFORMANT: Mrs Walter G Rill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 10 mo.

151 / 46 b

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-29-48 | 19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1948, to 8-17, 1949, that I last saw the deceased alive on 8-17, 1949, and that death occurred at 7:37 p.m., from the causes and on the date stated above.

SIGNATURE Maurice C. Porter (Degree or title) ADDRESS Hampstead Md DATE SIGNED 8/18/49

23. BURIAL, CREMATION / REMOVAL (Specify) Burial | DATE THEREOF aug 20/49 | NAME OF CEMETERY OR CREMATORY Hampstead | LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REG. Aug 18, 1949 | REGISTRAR'S SIGNATURE John S. Hughes Jr | 24. FUNERAL DIRECTOR Edw A Tipton | ADDRESS Hampstead Md

VS. A15

RECEIVED
AUG 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 07720

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1yr.8mos. 3days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 25
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location): 730 Bridgeview Rd.(Cherry Hill) ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
EDITH	CORONA	RUSSELL	August	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Married	Nov., 21,1916	32 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		DCity Hall, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Watkins	Jeannette Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Unknown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	July,1942
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 15, 1947, to Aug. 20, 1949, that I last saw the deceased alive on Aug., 20, 1949, and that death occurred at 10:20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hofman, M.D.	Henryton, Md.	8/20/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR ~~CREMATORY~~	LOCATION (City, town, or county)	(State)
Burial	8-25-49	Mount Calvary	A.A. Co.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/20/49	Albert R. Swankham	Charles R. Law	802 Madison Ave-1

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 24 1949
BUREAU V. S.

07721

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll -
City or town: Rural Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa County: Dauphin
City or town: Harrisburg Pa
(If outside city or town limits, write RURAL and give nearest town)
Street No.: - 2623 N. 5th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Annie Metilda Schaenzlin

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: W -
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Frederwinke W. Schaenzlin
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 31, 1884
8. AGE: Years: 65 Months: 0 Days: 0 If less than one day: hrs. min.
9. Birthplace: Ickesburg, Pa (Town, county, and state)
10. Usual occupation: House Wife -
11. Industry or business:
FATHER 12. Name: Phillip Keil
13. Birthplace: Pa.
MOTHER 14. Maiden name: Pennisah Dromgold
15. Birthplace: Pa
16. Informant: Mrs Wm Nevins
Address: Manchester, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/2/49 (month) (day) (year)
Cemetery or crematory: Sandla Cemetery
Location: Ickesburg, Pa. Perry County
18. Funeral director: Jacob Wirth & Sons
Address: Manchester, Md.
19. Aug 31 1949 M.D. H.R.S Denver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1949 at 12:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1948 to Aug 31 1949 and that I last saw her alive on Aug 30 1949

	DURATION
Immediate cause of death - Coronary Thrombosis	7 days
Due to: arteriosclerosis -	?
Due to: Diabetes -	3 yrs
Other conditions	

260
61
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Froard M. D.
M. D. or other
Address: Manchester Md Date signed: 8/31/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
SEP 1 1949
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07722

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER
LENGTH OF STAY (in this place): 10 MONTHS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: CARROLL COUNTY HOME

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WESTMINSTER
STREET ADDRESS (If rural, give location): CARROLL COUNTY HOME

3. NAME OF DECEASED (Type or Print): (First) AMANDA (Middle) H. (Last) SNYDER

4. DATE OF DEATH: (Month) AUG. (Day) 20 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOW	SEPT. 9. 1870	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	U.S.A.

13. FATHER'S NAME: JESSE LONG

14. MOTHER'S MAIDEN NAME: ANNA GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
No	—	NONE	JOHN LONG

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Disease of Coronary Arteries	3 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetis for 10 years	
	(c) Senility	

260
61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
none m.	—	—

22. I hereby certify that I attended the deceased from about Aug. 1st, 1925, to Aug. 20th, 1949, that I last saw the deceased alive on Aug. 19th, 1949, and that death occurred at 6 a. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. B. Billingslea		Westminster, Md.	8-21-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8/22/49	WESTMINSTER	WESTMINSTER	MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/24/49	[signature]	J. FRANCIS REESE	WESTMINSTER, MD.

RECEIVED
AUG 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07723 94

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Baltimore 9 Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville; LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) 2101 West Coldspring

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Albert	Stein	8	10	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	8-13-81	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
painter	—	U.S.A. (Baltimore)	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John K. Stein	Theresa Ball

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	—	Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arteriosclerosis	7 years
962 97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) posttraumatic mental deterioration due to skull-fracture	7 years
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ / Not While At work ☐	HOW DID INJURY OCCUR?
— m.		/

22. I hereby certify that I attended the deceased from Sep. 1, 1947, to August 10 1949, that I last saw the deceased alive on 8-10, 1949, and that death occurred at 8, 58 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Grow	M.D.	Sykesville, Md.	8-10-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/13/49	Loudon Park Cem.	Balto., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/11/49	A. W. Hedrick	WM. J. TICKNER & SONS	Balto., Md.

JS

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: CARROLL
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL WESTMINSTER
LENGTH OF STAY (in this place): 50 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ROUTE 4

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL WESTMINSTER
STREET ADDRESS (If rural, give location): ROUTE 4

3. NAME OF DECEASED (Typo or Print): (First) IDA (Middle) MISSOURI (Last) STEPHAN

4. DATE OF DEATH: (Month) AUG. (Day) 25 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: Nov. 27 1868

9. AGE last birthday: 80 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY YINGLING

14. MOTHER'S MAIDEN NAME: ELIZABETH MASSMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FRANKLIN I. STEPHAN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Decompensation	12 hours
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Hemorrhage	6 mo
950	(c) Arterio sclerosis	10+ yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 July, 1949, to 25 Aug, 1949, that I last saw the deceased alive on 24 Aug, 1949, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Chas. R Fouty MD ADDRESS: Westminster md DATE SIGNED: 8.27.49

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL
DATE: 8/29/49
NAME OF CEMETERY OR CREMATORY: LEISTER'S CEMETERY
LOCATION (City, town, or county) (State): NR. WESTMINSTER MD.

DATE REC'D BY LOCAL REG.: 8/27/49
REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: J. FRANCIS REESE WESTMINSTER, MD.

VS. A15

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AUG 30 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07725

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor Rural
LENGTH OF STAY (in this place): Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor Rural
STREET ADDRESS (If rural, give location): near New Windsor

3. NAME OF DECEASED (Type or Print): (First) Emily (Middle) Jane (Last) Stitely

4. DATE OF DEATH: (Month) Aug (Day) 1 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 18-1870

9. AGE last birthday: 79 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Gruton Wagner

14. MOTHER'S MAIDEN NAME: Elizabeth Hudrear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs Guy Baile

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): Arteio Sclerosis

450.0 Antecedent cause(s)

99 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan -, 1948, to July 31, 1949, that I last saw the deceased alive on July 31, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): J. N Legg m d — ADDRESS: Union Bridge Md — DATE SIGNED: 8-1-49.

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE: 8/3/49 — NAME OF CEMETERY OR CREMATORY: Union Chapel Cem. — LOCATION (City, town, or county) (State): Frederick County, Md

DATE REC'D BY LOCAL REG: Aug 2/49 — REGISTRAR'S SIGNATURE: Oscar L Pindell

24. FUNERAL DIRECTOR — ADDRESS: W. O. Harbaugh & Sons Union Bridge & New Windsor, Md

RECEIVED
AUG 8 1949
BUREAU V. S.

07726

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Katherine Hereford Stoddert

4. DATE OF DEATH (Month) (Day) (Year): Aug 5th 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Apr 29-1876

9. AGE last birthday: 73 yrs. — If under 1 year: Months 3, Days 7 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Union W Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Hereford

14. MOTHER'S MAIDEN NAME: Alice Coperton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Com. T. B. Stoddert

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 wk
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Genl. Arterio Sclerosis	5 yrs
	(c)	

331

83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 2, 1945, to Aug 5, 1949, that I last saw the deceased alive on Aug 5, 1949, and that death occurred at 5 a.m., from the causes and on the date stated above.

SIGNATURE: M. J. Wastin (Degree or title) MD — ADDRESS: Sykesville Md — DATE SIGNED: Aug 5-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Aug. 6, 1949 — NAME OF CEMETERY OR CREMATORY: Greenmount cem. — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: Aug. 5, 1949 — REGISTRAR'S SIGNATURE: C. H. Weer

24. FUNERAL DIRECTOR: C. H. Weer — ADDRESS: Sykesville

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
AUG 8 1949
BUREAU V. S.

07727

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
LENGTH OF STAY (in this place) 1 Month 3da
HOSPITAL OR INSTITUTION OR STREET ADDRESS Longview Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY York
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) A (Last) Tome

4. DATE OF DEATH (Month) August (Day) 26 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug 26, 1861
9. AGE last birthday 88 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Supervisor
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Maytown Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Tome
14. MOTHER'S MAIDEN NAME Rosanna Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Nursing Home Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	?
442 Antecedent cause(s)	(b) Arteriosclerotic Cardio Renal Vascular	
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Disease	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July 23, 1949, to Aug 26, 1949, that I last saw the deceased alive on Aug 26, 1949 and that death occurred at 11 A. m., from the causes and on the date stated above.

SIGNATURE Joseph E Bush (Degree or title) MD ADDRESS Hampstead Md DATE SIGNED Aug 26, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug 28 1949
NAME OF CEMETERY OR CREMATORY Union Cemetery
LOCATION (City, town, or county) Maytown (State) Pa

DATE REC'D BY LOCAL REG. Aug 26/49
REGISTRAR'S SIGNATURE Mrs. W. P. S. Denner
24. FUNERAL DIRECTOR W. A. Feiser Hanover ADDRESS Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 07728

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; LENGTH OF STAY (in this place) 4 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) 202 N. Charles St. ✓

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Elizabeth (Last) Darley

4. DATE OF DEATH: (Month) Aug (Day) 16 (Year) 1949

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH Dec 29 1864

9. AGE last birthday 85 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Robert Towne

14. MOTHER'S MAIDEN NAME Frances Ann Kirby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Charles Frederick.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Terminal Hypostatic Pneumonia — Interval Between Onset and Death: 1 da.

334 / 97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral Arterio Sclerosis — 10 yrs

(c) Hypertension — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 9, 1949, to Aug 16, 1949, that I last saw the deceased alive on Aug 16, 1949, and that death occurred at 2-30 p. m., from the causes and on the date stated above.

SIGNATURE H. H. Martin (Degree or title) M.D. ADDRESS Sykesville Md. DATE SIGNED Aug 16-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Aug. 18, 1949

NAME OF CEMETERY OR ~~CREMATORY~~ Cedar Hill

LOCATION (City, town, or county) (State) Anne Arundel

DATE REC'D BY LOCAL REG. 8/12/49

REGISTRAR'S SIGNATURE H.W. Hedrick

24. FUNERAL DIRECTOR ADDRESS Wm. J. Tickner & Sons Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07729

Reg. Dist. No. 74

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Havre de Grace
STREET ADDRESS (If rural, give location): 524 Young Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIE	ROBERT	VICKERS	August	1,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Single	May 28, 1910	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Fitzgerald, Georgia	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edgar Vickers	Ireatha Wilcox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	?	Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	June 10,
002 Antecedent cause(s)		1949
138 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 27, 1949, to Aug. 1, 1949, that I last saw the deceased alive on Aug. 1, 1949, and that death occurred at 8:35 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Md.	8/1/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-4-49	St. James	Havre de Grace, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/1/49	Albert R. Sundstrom Deputy Local	R. Madison Mitchell	Havre de Grace, Md.

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Bc 07730

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton,
LENGTH OF STAY (in this place) 7mos. 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 17
STREET ADDRESS (If rural, give location) 404 McMechen St.,

3. NAME OF DECEASED (Type or Print) (First) BERNARD (Middle) (Last) WAGNER

4. DATE OF DEATH (Month) Aug., (Day) 4 (Year) 1949

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.,
8. DATE OF BIRTH Nov., 13,1919
9. AGE last birthday 29 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Roland Wagner
14. MOTHER'S MAIDEN NAME Agnes Covington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) II
16. SOCIAL SECURITY NO. ?
17. INFORMANT Deased Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Aug.,1948

002

Antecedent cause(s)

13b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 17, 1948, to Aug., 4, 1949, that I last saw the deceased alive on Aug., 4, 1949, and that death occurred at 1:00 A. m., from the causes and on the date stated above.

SIGNATURE Reuben Hoffman, M.D. (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 8/4/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 8/9/49 NAME OF CEMETERY OR CREMATORY Balto Natl Cem LOCATION (City, town, or county) Balto Md (State)

DATE REC'D BY LOCAL REG. 8/4/49 REGISTRAR'S SIGNATURE Albert R. Swankham Deputy Local

24. FUNERAL DIRECTOR Chas G Wolper 512 Canvelton Av ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

17731

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton — LENGTH OF STAY (in this place) 11mos. 2days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) R.F.D. #2 Lake St.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	JOHN	WESLEY	WALDER		Aug.,	22	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Single	Jan., 1, 1928	21 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harrison Waller
14. MOTHER'S MAIDEN NAME: Lillian Waller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-12-0604
17. INFORMANT: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Jan., 1948

002

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

137

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 20 19 48, to Aug. 22, 19 49, that I last saw the deceased alive on Aug. 22, 19 49, and that death occurred at 11: A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Robert W Bruce, M. D.	Henryton, Maryland	8/22/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-25-49	Mardela Springs Cem	Mardela Springs, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/22/49	Albert R. Trueblood, Deputy Local	Herbert M. St. Clair, Jr.	Cambridge Md

VS. A15

RECEIVED
AUG 26 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 07732

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton, LENGTH OF STAY (in this place) 10 mos. 19 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural, give location) 1212 N. Central Ave.,

3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) HENRY	(Last) WASHINGTON	4. DATE OF DEATH	(Month) Aug., (Day) 10 (Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 28, 1890	9. AGE last birthday 59 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Leonard Washington		14. MOTHER'S MAIDEN NAME Alice Camden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 219-01-6281	17. INFORMANT Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — April, 1946

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 22, 1948, to Aug., 10, 1949, that I last saw the deceased alive on Aug., 10, 1949, and that death occurred at 6:40 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Md.	8/10/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 13-49	Mt Calvery Cem	Brooklyn Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/10/49	Albert R. Swanthram	Chas O. Wilson	1000 Bentley ave

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

117733

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — STATE: MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (In this place): 4 yrs
   HOSPITAL OR INSTITUTION, OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY:
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
   STREET ADDRESS (If rural give location): 1382 Clement St

3. NAME OF DECEASED (Type or Print): (First) Charlotte (Middle) (Last) Beaver

4. DATE OF DEATH: (Month) Aug (Day) 10 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Mar 28 1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months 4 Days 16 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Anderson

14. MOTHER'S MAIDEN NAME: Elizabeth Shrewsbury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: George Beaver

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	10 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus	4 yrs
422.1 61	(c) Gen. Arterio Sclerosis	10 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 11, 1949, to Aug 10, 1949, that I last saw the deceased alive on Aug 10, 1949, and that death occurred at 6-25 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): M. A. Martin M.D. — ADDRESS: Sykesville Md — DATE SIGNED: Aug 10-49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial — DATE THEREOF: 10/13/49 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county) (State): Glenburnie, Md.

DATE REC'D BY LOCAL REG.: 8/10/49 — REGISTRAR'S SIGNATURE: C. Harry Weer

24. FUNERAL DIRECTOR — ADDRESS: John F. Denny - Light & Montgomery Balto. Md.

RECEIVED
AUG 11 1949
BUREAU V. S.

07734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesvilla — LENGTH OF STAY (in this place): 4 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) Harvey	(Middle) Spencer	(Last) Wineholt	4. DATE OF DEATH	(Month) Aug.	(Day) 13	(Year) 1949
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) wid.	8. DATE OF BIRTH: 3-16-75	9. AGE last birthday: 74 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper and Miller	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore Co, Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME: Killian B. Wineholt	14. MOTHER'S MAIDEN NAME: Hannah Matilda Keeney						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT: Records of Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arteriosclerosis	4 years
450.0 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Involutional psychosis	4 years

19a. DATE OF OPERATION: ----	19b. MAJOR FINDINGS OF OPERATION: ----	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): ----	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----	(CITY OR TOWN) (COUNTY) (STATE): ----
TIME OF INJURY (Month) (Day) (Year) (Hour): ---- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Aug. 13, 1949, that I last saw the deceased alive on Aug. 12, 1949, and that death occurred at 5.30 a.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) ADDRESS Sykesville, Md. DATE SIGNED 8-13-49

Martin Gross, M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Aug. 16	NAME OF CEMETERY OR CREMATORY: Bethel Chapel G.	LOCATION (City, town, or county) (State): York Co. Pa
DATE REC'D BY LOCAL REG.: Aug. 15, 1949	REGISTRAR'S SIGNATURE: C. Harry Weer	24. FUNERAL DIRECTOR: W. A. Feiser	ADDRESS: Hanover, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07735

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead; LENGTH OF STAY (in this place) 13 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓; STATE MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) FRANKLIN (Middle) MILTON (Last) WOLFE

4. DATE OF DEATH: (Month) August (Day) 5 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.

8. DATE OF BIRTH: 12-31-1935

9. AGE last birthday: 13 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer.

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mary E Wolfe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-28-4013

17. INFORMANT: Mr Royer Wolfe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Electrocution

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Contact with high tension wire

(c)

914.4
193

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Carnival Grounds (CITY OR TOWN) Hampstead (COUNTY) Carroll (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 5 1949 12 25 A m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? He boy caught hold of high tension wire

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE James T Hood (Degree or title) Deputy Medical Examiner ADDRESS Westminster Md DATE SIGNED Aug 5. 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Aug 7/49 | NAME OF CEMETERY OR CREMATORY Meadow Branch | LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. Aug 5, 1949 | REGISTRAR'S SIGNATURE John S. Hughes Jr.

24. FUNERAL DIRECTOR Edw C Tipton ADDRESS Hampstead Md

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BUREAU V. S.